MEDICAID SUPPORT OF EVIDENCE-BASED PRACTICES IN MENTAL HEALTH PROGRAMS

INTRODUCTION

In 2002, by Executive Order, President George Bush created the President's New Freedom Commission on Mental Health (the Commission) whose mission was to conduct a comprehensive study of the U.S. mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. Over the last decade, research in the field of mental health has demonstrated that there exists consistent scientific evidence that some specific practices work well to improve outcomes in the lives of individuals with severe mental illness. National studies have shown, however, that most people with severe mental illness do not have access to services that have proven to be effective.

The Commission identified several key principles for enabling adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate in their communities. One principle in particular calls for an increase in the quality of services delivered, including consideration of how mental health research findings can be used most effectively to influence the delivery of services. For a program to be rated as having a strong or very strong evidence-base, it must have demonstrated positive outcomes both in carefully controlled research and in "real-world" settings.

In support of this principle, the Centers for Medicare and Medicaid Services (CMS) has assembled from the professional literature in the field the following descriptions of six evidence-based practices (EBPs) shown to be effective for individuals with mental illness. Following each description is a short discussion of the role of Medicaid services to support all or part of the practice.

MEDICAID STATE PLAN AND WAIVER PROGRAM BASICS

The Medicaid State Plan

The Medicaid benefits package is broad – there are some 30 statutory categories of services listed in Section 1905(a) of the Social Security Act (the Act) for which Federal Medicaid matching funds are available. Some of these categories are "mandatory" meaning States must provide them if they choose to participate in Medicaid. Other categories are "optional" meaning states may provide them if they so choose. Some examples of mandatory and optional services that support EBPs are:

Mandatory:

- Physicians' services -- 1905(a)(5)(A) and 42 CFR 440.50
- Inpatient hospital services -- 1905(a)(1) and 42 CFR 440.10
- Outpatient hospital services -- 1905(a)(2)(A) and 42 CFR 440.20
- Federally-qualified health center (FQHC) services -- 1905(a)(2)(C) and 1905(l)(2)(B)), and 42 CFR 491.1 - 491.11
- Rural health clinic (RHC) services -- 1905(a)(2)(B), 1905(l)(1) and 42 CFR 440.20(b), (c)
- Laboratory and x-ray services -- 1905(a)(3) and 42 CFR 440.30

Optional:

- Rehabilitation services -- 1905(a)(13) and 42 CFR 440.130(d)
- Medical care or remedial care furnished by licensed practitioners under State law -- 1905(a) (6) and 42 CFR 440.60
- Prescribed drugs -- 1905(a)(12) and 42 CFR 440.120
- Clinic services -- 1905(a)(9) and 42 CFR 440.90
- Targeted Case Management services -- 1915(a)(19), 1915(g)

Fundamental elements must be present for CMS's approval of a state plan amendment (SPA) that proposes services in support of evidence-based practices. Therefore, the CMS SPA review process will look for proposals that include basic Medicaid program fundamentals such as:

- Compliance with Laws and Regulations. Services must be provided in accordance with all applicable laws and regulations governing the benefit category used for coverage of mandatory and optional services as listed above.

- Medical Services. Because Medicaid's primary purpose is to help fund *medically necessary services*, state plan services in support of EBPs must be medical services, not merely principles, contained in the components of each evidence-based practice.

- Provided to Medicaid-Eligibles. Medicaid only reimburses services provided to Medicaid-eligible individuals. Therefore, EBP treatment services must be provided directly to, or for the direct and exclusive benefit of, the Medicaid beneficiary.

- Free Choice of Qualified Providers. States are required to assure that a recipient may obtain services from any willing, qualified provider. In instances where Federal law stipulates provider qualifications, those requirements must be met. Otherwise, States are free to establish their own provider qualifications according to state practice acts. Provider qualifications must be reasonable given the nature of the service provided and must not restrict providers. Therefore, Medicaid providers must meet all applicable Federal or State provider requirements and be practicing within their scope of practice under State law in order to bill for Medicaid services.

- Amount, Duration, and Scope. Services must be adequate in amount, duration, and scope to reasonably achieve their purpose.

- Comparability of Services. State plans must provide that the services are equally available to any categorically needy recipient under the plan, and are not less in amount, duration, and scope than those services available to a medically needy recipient.

- Third Party Liability (TPL). TPL refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the State plan. The Medicaid program by law is intended to be the payer of last resort. Individuals eligible for Medicaid must assign their rights to third party payment to the State Medicaid agency.

- Reimbursement Methodology. State plans must include a comprehensive description of the reimbursement methodology used for payment of each service within that plan. As required by Federal statute, States must have methods and procedures to assure that payments are consistent with economy, efficiency, and quality of care.

In addition, the CMS review process will also look to ensure that payment is not subject to payment exclusions found in Section 1905(a) of the Social Security Act. When provided in accordance with Federal Medicaid fundamentals such as those listed above,

States are free to take advantage of the flexibility inherent in the Medicaid program by utilizing one or more different State Plan benefit categories in cooperation with each other to support and reimburse EBPs. Mandatory and optional state plan benefits such as those mentioned earlier have been used in combination with each other by States to create an enhanced, comprehensive package of services in support of EBPs. For example, some States covering Assertive Community Treatment (ACT) programs have utilized the Rehabilitation option to fund the medical services in their ACT program, while other States have utilized the Rehabilitation option combined with other optional benefits such as Transportation, Targeted Case Management, and Personal Care, to provide a more comprehensive package of ACT services.

Additionally, comprehensive packages of services in support of EBPs also may be created using other Medicaid funding authorities. For example, services not coverable under the state plan such as supported employment, prevocational training, and respite, can be covered to some extent under the Section 1915(c) home and community based waiver (HCBW) services authority. States may also utilize section 1915(b) managed care waivers to fund services through savings.

Medicaid Managed Care Waivers – Section 1915(b) of the Act

All of the services that are Medicaid reimbursable through the state plan are potentially also reimbursable under the authority of a 1915(b) managed care waiver. Section 1915(b) of the Act authorizes waivers to increase access to managed care and test innovative health care financing and delivery options. With a managed care waiver, States may mandate enrollment of Medicaid eligibles in managed care programs and waive certain Medicaid requirements in Sections 1902 and 1903 of the Act such as Freedom of Choice (1902(a)(23)), Statewideness (1902(a)(1)) and Comparability of Services (1902(a)(10)). Section 1915(b) waivers are commonly being used by States to implement mandatory enrollment Medicaid managed care programs, both for general health care and for "carveout" programs that target specific types of services.

Medicaid Support of EBPs in 1915(b) Waivers. The EBP services supported through the Medicaid State Plan also could be supported through a managed care delivery system. In addition, Section 1915(b) (3) of the Act allows States to request a waiver permitting the use of cost savings to provide additional health-related services to beneficiaries. Through the use of 1915(b)(3) savings, States have the flexibility to provide health related services that would normally not be covered under the State Plan, such as some elements of Supported Employment services. These savings, however, cannot be utilized to provide services to residents of an Institution for Mental Disease (IMD).

Medicaid Home and Community-Based Services Waivers – Section 1915(c) of the Act

Section 1915(c) waiver authority permits a State to offer community alternative services to persons who otherwise would qualify for services in a Medicaid institutional setting (a nursing facility, ICF/MR, or hospital). Within the parameters of broad federal guidelines, states have the flexibility to develop Home and Community-Based Services (HCBS) waiver programs designed to meet the specific needs of targeted populations. Under the HCBS waiver authority, states may request waivers of certain federal requirements such as Statewideness (1902(a) (1)), Comparability of Services (1902(a) (10)), and Income and Resource Rules (1902(a) (10) (C) (i) (III)) in order to develop community-based treatment alternatives. States may offer a variety of services to consumers under an HCBS waiver program and are not limited to the number of services that can be provided. States may use an HCBS waiver program to provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, and environmental modifications).

Medicaid Support of EBPs in 1915(c) Waivers. Due to the flexibility under this authority, many EBP services could be provided through a 1915(c) waiver if the State can demonstrate the services will prevent a recipient from being institutionalized and is cost effective. Despite this flexibility, the HCBS waiver option has not been widely utilized to support the provision of community-based services to adults with a mental illness. A 1915(c) waiver may not serve as an alternative to services in an IMD since Federal Financial Participation (FFP) is not available for those services. States may be permitted to provide home and community-based waiver services to persons with mental illness who receive Medicaid-funded care in a nursing facility. As of June 2005 there are currently five HCBS waivers targeted to children with a mental illness, and one waiver (Colorado) targeted specifically to adults age 18 and over with a mental illness.

SUMMARY OF EVIDENCE-BASED PRACTICES

Here are descriptions of six evidence-based practices (EBPs) shown to be effective for individuals with mental illness. Following each description is a short discussion of the role of Medicaid services to support all or part of the practice.

Medication Management

This systemic approach translates the latest available knowledge about medications into practical pharmacotherapy suggestions and promotes optimal recovery in the consumer population. Major activities under medication management may include: *medication evaluation* – making an acute diagnosis and specifying target symptoms and initial severity; *medication prescription* – prescribing the type and dose of medication(s) designed to alleviate the symptoms identified above; *medication monitoring* – monitoring

changes in symptoms, occurrence and tolerability of side effects as well as reviewing data used in making medication decisions; *individual client education* – increasing consumer knowledge and understanding of the symptoms being treated, medications being prescribed, the expected benefits, impact on symptoms, and identification of side effects.

Medicaid Support of Medication Management Services. Medicare will begin to cover the cost of drugs in January 2006. However medication management pertains to the oversight and coordination of an individual's use of the drugs and monitoring any side effects that may be produced. When medication management is coupled with other medical and supportive services, it has been shown to result in improved outcomes. The services described above would be reimbursable under Medicaid. States that choose to provide medication management services in a community based setting can do so under a variety of Medicaid state plan benefits such as the Clinic benefit, the Rehabilitation benefit, and the Medical or Other Remedial Care Provided by Licensed Practitioners benefit. The Inpatient and Outpatient Hospital benefits would support individuals receiving services in an institutional setting. In addition, it is possible to claim case management activities that assist Medicaid-eligible individuals to gain access to needed medical, social, educational, and other services under the Targeted Case Management (TCM) benefit. The TCM benefit may assist an individual in gaining access to medication management, but does not provide the service itself.

Medicaid Coverage – State Review Questions. Questions a State should ask itself in conjunction with submitting an amendment:

Q. What are the medication management services provided?
Q. Under what service categories is medication management furnished?
Q. What are the qualifications of providers of medication management services?
Q. Are all providers rendering the medication management service under State scope of practice acts?
Q. What, if any, services will be provided by individuals working under supervision? Please describe the supervisory arrangements.

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a multi-disciplinary clinical team approach providing comprehensive mental health and rehabilitation services. Team members provide long-term intensive care in natural community settings. The team provides all services rather than referring clients to different providers, programs, or other agencies. Major activities under ACT may include: *client specific team treatment planning* – team meets daily to plan services, assess clients clinical and community status and share information to coordinate services; *individual supports* – for activities of daily living, financial management, skills training, medication support; *coordination with collaterals* – sharing information with healthcare and other providers; *individual clinical interventions* – therapy, diagnosis, and assessment.

Medicaid Support of ACT. Many States currently include many assertive community treatment services in their state plans. In general, the Rehabilitation Services benefit is primarily used to help support ACT programs. Other benefits such as Clinic Services, Personal Care Services, Transportation Services, and the Medical or Other Remedial Care Provided by Licensed Practitioners also can be used to support the provision of many community-based ACT services. In addition, it is possible to claim case management activities that assist Medicaid-eligible individuals to gain access to needed medical, social, educational, and other services under the Targeted Case Management benefit.

Medicaid Coverage – State Review Questions. Questions a State should ask itself in conjunction with submitting an amendment:

Q. What is the composition of the treatment team?
Q. What are the provider qualifications of each team member?
Q. What Medicaid services are included in the State's ACT program?
Q. How will the ACT program be coordinated with other community based supports?

Supported Employment

Supported employment is a comprehensive approach to vocational rehabilitation whereby the employment specialist works with the individual, the family, and the treatment team (practitioners who provide services such as case manager, therapist, psychiatrist) to integrate supported employment with mental health treatment toward promoting recovery. The goal of supported employment is to help people with the most severe disabilities participate in the competitive labor market, work in jobs they prefer with the level of professional help they need, and help people advance in their careers. Major activities may include: *employment assessment* – assessment is based on a person's interests, skills, and prior experience and primarily occurs in the community; *job training* – assistance for the individual to begin work, learn the job and interact appropriately with co-workers, customers, and supervisors (coaching, teaching, assistive technology, and accommodations); *ongoing support to maintain employment* – offered are career development, access to educational opportunities, coaching, vocational educational classes, job counseling, transportation, changes in the treatment plan, and assertive outreach to the client.

Medicaid Support of Supported Employment Services. Vocational training is among the few services statutorily excluded from Medicaid reimbursement. Therefore, under the State Plan, Medicaid cannot pay for the employment of an individual. Similarly, payment may not be made for employment assessments or ongoing support to maintain employment except under an HCBS waiver. However, Medicaid can pay for the medical services that enable an individual to function in the workplace. The evidence-based components of supported employment that integrate medical services such as a

psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling are Medicaid reimbursable services that States may cover. States that choose to provide integrated treatment services as part of a supported employment services program often cover the services under the Medicaid Clinic benefit, the Rehabilitation benefit, or the Medical or Other Remedial Care Provided by Licensed Practitioners benefit since those benefits best support community-based services. States also may use the Targeted Case Management benefit to claim case management activities that assist Medicaid-eligible individuals to gain access to needed medical, social, educational, and other services.

Medicaid Coverage – State Review Questions. Questions a State may ask itself in conjunction with submitting a waiver or amendment:

Q. What Medicaid services are included in the Supported Employment program?
Q. Are any other sources responsible for funding some the supported employment services?
Q. What steps are being taken to ensure that Medicaid pays only for covered services?

Family Psychoeducation

Family psychoeducation is a method of working in partnership with families to impart current information about mental illness, to assist with developing coping skills for supporting recovery, and to encourage problem solving strategies for managing issues posed by mental illness in their family. Clinicians establish a bond with a client and his/her family members to help the family system develop increasingly sophisticated coping skills for handling problems posed by mental illness in a family member. Major activities may include: *individual family counseling* – time to review illness history, warning signs, coping strategies, and concerns and develop goals; *family treatment planning* – active involvement of family members in the planning and input of setting goals and treatment; *family supports* – helping families support their loved ones who have mental illness in their recovery. Medicaid payment is limited to activities performed for the direct benefit of the Medicaid recipient.

Medicaid Support of Family Psychoeducation. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual would not be eligible for Medicaid reimbursement. For example, consultation with other family members can be a necessary part of planning and providing care to patients in need of psychiatric services. Consultation can, however, devolve to a point where it becomes a means of treating others rather than, or in addition to, the primary recipient. Medicaid would not reimburse for services provided to ineligible family members for treatment of their problems not related to the treatment of the Medicaid patient. In addition, Medicaid would not reimburse for family psychoeducation classes that are not part of a treatment plan tailored specifically toward the Medicaid beneficiary.

A variety of Medicaid State Plan benefits may be used to support the provision of family psychoeducation. For example, benefits such as Rehabilitation and Clinic Services are often used because they are flexible and best support community-based services. It also is possible to use the Licensed Practitioners benefit for services provided by State-licensed providers such as physicians, psychologists, and licensed clinical social workers. States also may use the Targeted Case Management benefit to claim case management activities that assist Medicaid-eligible individuals to gain access to needed medical, social, educational, and other services.

Medicaid Coverage – State Review Questions. Questions a State may ask itself in conjunction with submitting an amendment:

Q. What Medicaid services are included in family psychoeducation?
Q. Are all family psychoeducation services being provided to or directed exclusively toward the treatment of the Medicaid eligible individual?

Illness Management and Recovery

Illness management and recovery are a broad set of strategies designed to help individuals with serious mental illness manage their mental illness, reduce their susceptibility to the illness, cope effectively with their symptoms, identify supports that are effective for them, and advocate for receiving those supports. Recovery education and illness management are approaches that promote hope, healing, and empowerment. Major activities may include: *individual skills/illness self-management training* – focus on improving social functioning skills and includes cognitive behavioral (learning oriented) interventions including modeling, role-playing, practice, homework, shaping, and reinforcement; *individual counseling* – teaching individuals how their thinking styles and beliefs influence their feelings, and helping them to evaluate and change thoughts that lead to depression, anxiety, and anger; *group therapy* – cognitive-behavioral strategies to reduce severity and distress of persistent symptoms and promote personal insight within a group dynamic; and, *support to develop a crisis plan* – includes identification of early warning signs of crisis and details about preferred supports.

Medicaid support of Illness Management and Recovery Services. States that choose to provide medical services such as therapeutic counseling and cognitive behavioral interventions as part of an overall illness management and recovery services program can do so under a variety of Medicaid State plan benefits. Those best supporting community-based services include the Rehabilitation benefit, the Clinic benefit, and Other Licensed Practitioners benefit. The Targeted Case Management benefit also is a viable service for claiming case management activities that assist Medicaid-eligible individuals gain access to needed medical, social, educational, and other services.

Medicaid Coverage – State Review Questions. Questions a State may ask itself in conjunction with submitting an amendment:

Q. What Medicaid services are included in illness management and recovery?
Q. Are all illness management and recovery services being provided to or directed exclusively toward the treatment of the Medicaid eligible individual?
Q. What are the qualifications of providers of illness management and recovery services?
Q. Are all providers rendering service under State scope of practice acts?

Integrated Mental Health and Substance Abuse Treatment (Co-Occuring Disorders: Integrated Dual Disorders Treatment)

Integrated mental health and substance abuse treatment is a coordinated approach in which both disorders are treated simultaneously by the same treatment team. Treatment interventions are conceptualized in stages. Individual and group supports are used. Major activities may include: *assessment* – evaluating substance use, mental illness, and the impact of co-occurring disorders, also identifying which stage of change the client is in, in relation to their substance use and mental illness; *outreach* – motivational based interventions and practical assistance with the goal of engaging the client in treatment; *group therapy* – groups designed to reflect each stage of change including engagement, persuasion, active treatment, and relapse prevention; and, *family supports* – social network building or family interventions to increase consumers' general support.

Medicaid Support of Integrated Mental Health and Substance Abuse Treatment. Evidenced-based components that integrate medical treatment services such as psychiatrist and/or other mental health practitioner's treatment and participation in recovery planning, therapy, and counseling are Medicaid reimbursable services that States may cover. States can provide the medical services through any of the Medicaid benefits that support community based services mentioned above.

Medicaid Coverage – State Review Questions. Questions a State may ask itself in conjunction with submitting an amendment:

Q. Are all integrated mental health and substance abuse treatment services being provided to or directed exclusively toward the treatment of the Medicaid eligible individual?
Q. What are the qualifications of providers of integrated mental health and substance abuse treatment?
Q. Are all providers rendering service under State scope of practice acts?